A sales rep arrives in the OR with a new piece of equipment, saying a surgeon plans to use it on a case that day. A surgeon’s office calls to schedule a procedure, but it is not listed in your OR’s scheduling system.

A call team arrives during the night to learn a surgeon plans to perform a procedure, and they are not sure he has privileges for it.

All of these are reasons why OR nurse leaders play a role in physician credentialing.

“I believe OR managers and directors are key gatekeepers for physician credentialing,” says Suzanne Moss Richins, MBA, DHA, FACHE. “You and your staff are where the action is—you’re there when physicians schedule cases or request a new piece of equipment.

“You also are the keeper of information needed for physician recredentialing. There is a lot of information in OR software and from events that happen in the OR that no one else knows about.”

Many nurses think the medical staff is responsible for credentialing.

“They are the screening mechanism, but credentialing and privileging are the responsibility of the governing board,” says Richins, who is chief operating officer at Kadlec Medical Center, Richland, Wash. She spoke at the Managing Today’s OR Suite conference Oct 19 to 21 in San Diego.

The Centers for Medicare and Medicaid Services underlined this fact last year in a guidance to state survey directors. The guidance, dated Nov 12, 2004, says the hospital’s governing board is responsible for ensuring all practitioners who provide medical care or conduct surgery are individually evaluated by the medical staff. They must have the qualifications and competencies for the privileges granted (www.cms.hhs.gov/medicaid/survey-cert/sc0504.pdf).

The Joint Commission on Accreditation of Healthcare Organizations is considering revised credentialing and privileging standards that will require detailed performance monitoring and clinical evaluation plans.

Richins answered nurses’ frequently asked questions about physician credentialing.

Q What is the best way to list procedures physicians are privileged for? We need a way to verify that a surgeon has privileges for specific procedures.

Richins. Many hospitals have gone to core privileging. Core privileges are procedures and treatments routinely covered in residency training. The core procedures also define “special privileges” for procedures and treatments that require additional training. For example, in general surgery, “special privileges” might be required for abdominal aortic aneurysm repair and bariatric surgery.

In a survey last year, Horty Springer & Mattern, a health care law firm that has an online privileging system, found 82% of hospitals responding had developed core privileges.

Often, when you go to verify privileges, all you can see are the core privileges, but no one tells you what these include. You can contact the medical staff office and request a copy of the core privileges, either in software or hard copy. Be sure this information is also available on off-shifts so call teams can consult it. You can’t monitor privileges or be the gatekeeper unless you know what is in the core privileges.
When does a surgeon need privileges for new technology? For example, there are a variety of technologies for endometrial ablation. If a surgeon has privileges for endometrial ablation, does he or she need privileges for each new form of technology?

Richins. The answer about new technology is to ask every time—there is no general statement.

The first thing I would do is call the chair of the service and ask, “Do you think this is different from what this surgeon has done before?” If the chair says it is not a new procedure, I would go with that response.

The sales rep may be able to tell you if a new piece of equipment requires additional training. But your credentialing committee makes the determination about privileges.

Another resource is the medical staff office. The medical staff office manager usually belongs to the professional society for credentialing specialists, which has an online forum, National Association of Medical Staff Services (www.namss.org). The manager can post a question to the forum and usually will have a response within a few hours.

For a major new service, such as bariatric surgery, our hospital has a whole process for developing the program, including physician privileging. Our governing board will not consider privileging for a new service until criteria are developed and all of the support services and equipment have been provided for.

Do you foresee a blurring of privileges as more interventional radiologists perform procedures that have been performed surgically? How are you handling this?

Richins. Yes, I think we will see this happening more often, with physicians being privileged across specialty lines. An example is cardiologists wanting to read nuclear medicine studies typically read by radiologists. At our hospital, this would be considered a “special privilege” of the requesting department. To decide whether to grant privileges, we would look to see if cardiologists are doing this nationally. If they are, we would look at the training required for radiologists to read nuclear medicine studies, and we would apply those same criteria to the cardiologists. The cardiologists would then have to demonstrate that they have had the training and are doing the number required annually to remain competent.

If no criteria have been developed nationally, we would organize a small group, perhaps with a physician from each specialty involved plus the credentialing chair, to develop the criteria.

What is the OR manager’s and director’s role in the recredentialing of physicians?

Richins. You play a critical role. Your department has information about physician practice that no one else has.

CMS requires physician reappointment at least every 24 months unless state law requires more frequent reappraisal.

If you have a good medical staff office, they will tell you 90 to 120 days before an individual is recredentialed that the office needs certain information from you, such as:

- the number of procedures the physician has performed
- low-volume alerts
- new procedures being performed.

This information is likely to be in the OR’s information system. Some information systems have low-volume alerts if the physician has not performed enough procedures to meet the criteria. If the alert comes up, the credentialing committee should have a mechanism for addressing that, such as requiring the physician to be proctored.

If the physician lists a new procedure he or she plans to do, the credentialing committee also should have a process for reviewing that. Where did the physician get training? Has he or she been proctored? Are there letters of reference? Just
because the physician has core privileges and some special privileges does not mean privileges are automatically granted for the new procedure.

**Being a good citizen**

Also relevant is information about whether the physician is a “good citizen.” Does he or she have good interpersonal skills and a professional demeanor?

If a physician is disruptive, that needs to be documented and reported to the senior administration. The administration may decide to provide education and have the physician sign behavior contracts. Some organizations are using a consultant, Joe Bujak, MD, who educates the medical staff about behavior and trains the chairs about interventions. Physicians can also be sent to the PACE Program (Physician Assessment and Clinical Education) at the University of California, San Diego, for an assessment and treatment. (See resources.)

There also may be subtle signs about physicians’ competence that need to be documented and forwarded to the appropriate administrator. Is your staff comfortable doing this if they witness an incident? You are part of creating a culture where these incidents can be brought forward (see related article, “Why don’t they do something?” on page 16).

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**Q** We are near a couple of other hospitals. Some physicians take their patients with complications to another hospital. Is there a good mechanism for tracking this?

**Richins.** Check your state law. Washington State has passed a law that allows us to share that information. You will need to find out what your state’s rules are for sharing that information.

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**Definitions**

Credentialing and privileging are activities to collect, verify, and evaluate data about the competence of practitioners to provide high-quality, safe patient care. The data are the foundation for objective, evidence-based decisions about appointment to the medical staff and recommendations to grant or deny privileges.

**Credentialing**

Credentialing involves collection, verification, and assessment of information in 3 areas:

- current licensure
- education and relevant training
- experience, ability, and current competence to perform the requested privileges.

Primary source verification of these credentials is sought.

**Privileging**

Privileging is authorization of a practitioner to provide specific patient care services based on factors such as licensure, training, experience, competence, health status, and judgment.

*Source: Adapted in part from Joint Commission on Accreditation of Healthcare Organizations. Proposed revisions to Medical Staff Credentialing and Privileging Standards. November 2005.*
‘Why don’t they do something?’

A surgeon nicks the bowel during a fertility procedure but doesn’t call in a specialist to do a repair.

Another surgeon frequently performs procedures other than the one scheduled, such as an abdominoplasty with a hysterectomy.

In another case, nurses on the postop unit notice one surgeon’s bariatric patients don’t seem to do as well as others after surgery. The signs are subtle but persistent. “Why don’t they do something?” is the buzz in the lounge.

Whose responsibility?

Whose responsibility is it to do something?

The ultimate responsibility lies with the hospital’s medical staff, administration, and board of directors.

But these incidents may not surface unless front-line staff are willing to come forward. In the nicked-bowel case, the first person to notice was the surgical technologist (ST) who was scrubbed on the case and saw fecal material on the Richardson retractor. The ST didn’t say anything. The nick wasn’t immediately repaired. The patient developed sepsis and had to have a colostomy.

“Often, the OR staff does not understand the importance of reporting these complications,” says Suzanne Moss Richins, MBA, DHA, FACHE.

“You often hear the comment, ‘Everyone knows about so-and-so.’” Yet the staff may be the only ones aware of issues that should be considered during physician credentialing and privileging. If the staff do not record and report these issues, the credentialing committee may not have information about a need to restrict privileges.

“I urge you as a manager to encourage the staff to write up these incidents,” she says. “If they won’t, then you should write them up.”

If you consistently find the staff are afraid to speak up because they fear the repercussions, you may need a culture change, she comments.

When Richins took her current position as chief operating officer at Kadlec Medical Center, Richland, Wash, she asked the chief of the medical staff and the chair of the governing board to come to the OR and speak to the staff. They said: “We want quality care. We want to make sure every practitioner here provides quality care. If you send an incident report and someone comes down on you, you need to tell your managers, and we will take care of it. Maybe this individual doesn’t need to have privileges here anymore.”

How do you communicate to the staff about the need to report?

“It really is education,” Richins says. “The question I ask them is, ‘Would you let this surgeon operate on your mother or your family members?’ Usually, that is pretty telling. If they say no, follow up by asking: ‘Why wouldn’t you?’ The answers may provide information that needs to go to the credentialing committee.

“You job is to emphasize to the staff that they are the patient’s advocate,” she says. Most hospitals have developed a medical staff quality committee to help address these situations. Some have a hot line individuals can call to request that a situation be reviewed. This committee then conducts a review and makes recommendations to the practitioner.

Another strategy is a “collegial intervention” with the physician in question. This is an informal session where 2 peers meet with the physician and say something like, “We want to give you a heads up. This is what we are hearing and seeing. For your benefit, you need to correct this.” They take brief notes. If the issues are corrected, the notes are discarded. But if the behavior continues or gets worse, “you have addressed it. You have a record,” Richins says.

In the case of the surgeon who nicked the bowel, when the incident was investigated, the hospital found there had been other incidents, and the surgeon lost his privileges.
Credentialing and privileging resources

**AMA Physician Profile Service**
Profile service for initial and reappointment credentialing.
https://profiles.amaassn.org/amaprofiles/

**Joe Bujak, MD, FACP**
Physician conducts education and interventions related to physician behavior.
www.kaiser.net/kc/html/speakers/bujak/bujak_frame.htm

**Centers for Medicare and Medicaid Services**
Medicare Conditions of Participation
42 CFR Section 482.

**Dealing with Disruptive Physicians: Developing a Culture of Zero Tolerance**
Video. HCPro. $395.
www.hcmarketplace.com/prod-530.html

**Greeley Company**
Education and publications on credentialing and privileging.
www.greeley.com/consulting.cfm?practice=Credentialing&content_ID=25261

**Horty Springer & Mattern**
Health care law firm sells an on-line privileging system with core and special privileges based on research.
www.privileging.com

**Joint Commission on Accreditation of Healthcare Organizations**
Medical Staff Standards
www.jcaho.org

**National Association of Medical Staff Services (NAMSS)**
Association for those managing credentialing, privileging, and regulatory compliance. Has an on-line discussion board.
www.namss.org

**Physician Assessment and Clinical Education (PACE) Program**
University of California, San Diego, program for assessment, evaluation, and remediation of deficiencies for physicians and other health professionals.
www.paceprogram.ucsd.edu/